Testimony
Commissioner Gwendolyn L. Harris
February 13, 2003

Good Morning Chairwoman Weinberg, Chairwoman Previte, Chairman Mattheussen and Chairman Vitale and members of your respective committees.

Thank you so much for inviting me to speak to all of you today.

It is an honor and a privilege to share with you my plan to transform our child protection system in New Jersey.

I view each and every one of you as a partner in this process -- a process that must transcend political ideology …and a commitment that must outdistance any and all political seasons.

As you are all aware, my visit here today comes in the aftermath of the death of Faheem Williams, a 7-year-old boy whose death has focused attention on deficiencies in the Division of Youth and Family Services.

Faheem was known to DYFS.

Faheem's brothers were known to DYFS.

Indeed, DYFS had a series of allegations on this family dating back some 10 years.

A review of DYFS case files on this family demonstrates a pattern of lack of supervision, substance abuse, deplorable living conditions, a transient lifestyle as well as physical abuse and neglect.

Despite all of that, the agency closed its files on this family in late 2001, without investigating recent reports that these three boys were being beaten and burned.

In my opinion, the staggering missteps in this case -- while particularly egregious and not representative of the entire system-- suggest significant flaws in our overall child protection system.

These significant flaws can be broken down into three key areas:

- Poor decision-making
- Lack of accountability
- Lack of coordination and communication with outside partners

Please allow me to walk you through the issues my review has uncovered.

DYFS received 11 allegations of abuse or neglect on this family.

And yet, each allegation was apparently considered in isolation, in a vacuum, with no consideration of the family's previous history.

And so, an investigation regarding deplorable living conditions was not considered in the context of a similar previous allegation, where the mother was required to attend parenting classes, but failed to comply.

An allegation that one of the children suffered a cut hand was not considered in the context of an identical claim the year before that was substantiated as medical neglect.

By viewing each incident in isolation, the caseworker and frontline supervisor left holes in the overall assessment of risk of harm to the children.

The Williams family had multiple problems that were seemingly intractable.

And yet, at no point in the agency's 10-year history with this very troubled family, do we have record of frontline staff involved with the family feeling compelled to bring the family's issues to the attention of a higher-level supervisor.

Conversely, we have no record of higher-level supervisors ever reviewing the work of their subordinates in this case, thereby missing an opportunity, perhaps, to change the course of decision-making in this case.

Moreover, despite clear danger signals and instability in the family, at no time did anyone associated with the Williams family seek legal intervention to have the children moved to a safe and stable home, or to compel relatives to produce the children when they couldn't be found.

There were other major problems.

The Williams children were not visited regularly by a DYFS worker, even though agency policy requires face to face regular contact.

The children were bounced from relative to relative with the apparent full knowledge of the agency, but without the requisite background checks or service linkages.

Although drug use and/or drug sales by the adults in these children's lives was openly noted in the case files, there was little or no follow-up to these concerns.

With all of this going on -- or not going on, as the case may be -- one cannot help but pose the question:

- to what extent did the lack of supervisory oversight or involvement give tacit approval to sloppy work and fail to hold anyone accountable?

- to what extent was the poor casework a symptom of larger systemic problems or inadequate supports and resources?

That is why my efforts to shore up our child protection system will stress not only an infusion of needed resources but will also focus on increased supervision, better decision-making, increased accountability at all levels of the child protection system and greater communication among all child-serving systems, inside and outside of the Department of Human Services.

My recommendations have been developed with considerable input from a wide variety of key stakeholders in the child protection system, including caseworkers, supervisors and independent children's advocates.

One thing is crystal clear: Our goal must be not to simply reform, but to *completely transform,* the Division of Youth and Family Services and to rethink the way in which we serve all children at the Department of Human Services.

All of this must be done, again, informed by our desire to require greater accountability, facilitate better communication and collaboration and improve our decision making relative to children and families.

Here is how I plan to do that:

Focus on: Decision Making

We must increase the participation of higher level staff who are more skilled and seasoned in the decision making process

And we must ensure that staff have better information available to them to make decisions.

Here's how we do this:

- Reduce the Span of Control for Casework Supervisors to less that 1:3 -- (We are adding 47 supervisors -- this will bring that ratio from over 1:4 to 1:2.8) [80% of the frontline staff has less than 5 years of experience]

- Add Case Practice Specialists -- experts in case practice -- so we have one in every District Office -- (We are adding 34 case practice specialists)

- Implement Team supervision and case handling -- this is an innovative idea that involves caseworkers and supervisors being actively involved in actual case handling

- Implement SACWIS -- (Statewide Automated Child Welfare Information System) We are expediting this at a cost of $3.6 million. We have expedited implementation. We will phase in modules. We will use interim applications.

- Fully implement Structured Decision Making -- We will expand the use of Safety and Risk Assessment Tools that give caseworkers guidelines and prompts to ask the right questions, make good assessments of immediate safety and future risk. I must emphasize that these assessments

are only tools to aid in decision making and will not replace good care practice or supervision.

Also, to implement this plan we must:

- Manage caseloads

  - Reduce high caseloads

    - Overall management control which includes working with staff to develop realistic plans to reduce high caseloads (including desk duty to reassignment of cases) **under no circumstance** will it mean that a case should be closed if the child is not safe
    - 20 percent of staff are trainees (50 percent trainees.. in one office)
    - Adding 65 caseworkers

  - Assign cases based on complexity and risk

    - Average caseload is 33, or 18 families
      Not all cases are the same (discuss methodology)

- Remove from Casework Staff those issues which detract from case practice activity and decision making.

  To do this we can:

- Add support staff: like – Para legals to perform functions like preparing court paperwork, or transportation aides to drive to people to doctors appointments

- Address safety concerns -- Host a "Safety Summit" and hire human service police to assist in the coordination of our work with local law enforcement, as well as to help with the locating of missing children

- Provide cars, cell phones, cameras and PCs

  - We have added 50 and will be obtaining 110 more to reach 2,100
  - We have added 370 we will buy more to reach 2,100 cell phones
  - We will buy 2,700 PCs by July

- Attract, train and keep good staff

  - 80 percent of staff have under 5 years

  - Hire a recruiter

  - Expand training

  - Facilitate movement into and out of child welfare

- Our success will be judged by our capacity to keep the good workers because they will stay if they feel supported, equipped, well trained, and proud of their ability to keep children safe

- We must continue to encourage staff feedback

  - There is much wisdom among our DYFS staff

  - They are keeping children safe every day

  - They helped shape this plan and they will be an integral part of the solution

  - We will create a mechanism to keep the feedback loop alive to both division and department administration

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Another critical component of my plan to transform our child protection system is the need to demand greater accountability across the entire system -- but especially among upper-level supervisors

Focus on: Accountability

Upper level supervisors and managers must be held responsible for the decisions of their staff. They should be

more closely monitoring activities, but they need the tools to assess the quality of work.

- Quality Service Reviews will be used for this

    - QSR's are case-specific – hiring an outside firm; they will put our work under a microscope, interviews and record review

    - Establish baseline -- to compare future progress

    - We will: Develop Internal Capacity to conduct on an ongoing basis

We will hold management staff accountable by establishing:

- Performance Measures for District Offices and Regions, based upon the quality service review

    - Report Card, Corrective Action monitored by the department's OPIA

    - Periodic QSR's for rereview

- Develop Leadership -- that embraces accountability

    - Accept American Public Human Service Association help to diagnose District Office's functioning

- Supervisory Training on How to Lead, Teach and monitor staff performance -- our local managers will advance the change process

- Use SACWIS data for performance tracking tool
  - Status of Child Visitation Requirements
  - Timeliness of Assessments
  - Use of Family Supports

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And the third vital component…

Communication and Collaboration

The multiple systems that impact the lives of children must communicate and coordinate their activities to better protect children.

- Family Group Counseling
  - An innovative model; Everybody has a seat at the table; A contract is developed; the model will be expanded statewide
- Welfare and DYFS

- We are serving the same people
- More than 40 percent of long-term welfare recipients are involved with DYFS
- And yet, there is uneven coordination of efforts
- Williams case showed that welfare checks were going out to provide support for the children, when DYFS couldn't find the kids

- Working with other systems -- including our sister departments
  - Education -- to report patterns of absenteeism among at-risk children
  - Health -- to identify abuse, for medical professionals to do joint investigations with us
  - Courts and Law Enforcement -- to let us know when a parent is incarcerated, or a caregiver has a child maltreatment conviction, or children are missing and there is an open allegation of abuse

- Working with the Larger Community to Prevent Child Abuse and Neglect
  - Work Group to discern Best Practices -- includes Rutgers School of Social Work, the foundation

community and the advocacy community

- Calling on Local, State and National Experts

- Developing Community Capacity and concern for those who have no one else (like Melinda Wms.) With our community partners, we must find a way to:

    1. Teach parents to parent. If you don't have a good mother, who's going to teach you to be one?

    2. Provide parents with appropriate support system. It would seem that Melinda Williams' support system involved many people whose lives were marginal themselves

- Warm Line by UMDNJ, Behavioral Sciences receive support from clinical professionals get referrals for services

Reconstitute DYFS and reorganize department

To really improve decision making, accountability, and communication and collaboration, we need to address the issue of DYFS's mission – it is too broad.

Child protection has to have its own organizational heartbeat

- DYFS has become Mikey -- ask DYFS -- they will do it when no one else can or will

- I propose a new division called the Division of Protection and Permanency -- which will focus on child protection and foster care and adoption

- I chose Permanency intentionally because it speaks to keeping families healthy and functional for their children, or moving children to adoption. In either case, children need a safe and stable home.

I also plan to organize this and all other child-specific services within the department under a Special Deputy Commissioner.

Under this plan,

- Most, if not all, child-centered services will be under the aegis of the new Special Deputy Commissioner; This could include such services as Kinship Care, the Office of Education and Child Support services.

- The Special Deputy also take charge of the new division -- the Division of Child Protection and

Permanency -- and will create another division for children's behavioral health which will include residential treatment currently under DYFS, the Partnership for Children Initiative and Children's Mental Health services

The premise of this restructuring is that clarity of mission, role and function will enhance clarity of decision making, accountability and cross system coordination.

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In closing, I would like to say that, clearly, the Department of Human Services recognizes that it has no greater responsibility than the protection and care of vulnerable children.

We are gratified that Governor McGreevey shares our concern, and that he has committed $20 million in his recommended SFY 2004 budget to DYFS.

But the Governor and I also recognize that more workers, more phones and more cars won't, alone, save our children.

Nor can the Department of Human Services, on its own, fix the problem.

We need the broad-based support and active participation of the larger community.

We must find a way to rebuild a collective sense of responsibility for children and families throughout all of our communities.

It is not about fixing DFYS. That suggests that there is a magical point at which, with enough staff or enough money, we can guarantee every child will be safe from harm.

I wish it were that easy.

But it isn't. Creating a public system that ensures children's safety is a dynamic and fluid process, a process that cannot be viewed as a destination but rather as a journey.

In order to first, stabilize, and then, transform, our child protection system, we must be mindful that we will be continually redefining success.

We must resist the temptation to declare victory and we must be vigilant in our efforts to keep children's welfare a number one priority.

Until we do, children will remain at risk, and those of us who are charged with leading this effort to change the system will have failed to give meaning to the death of Faheem Williams.

I look forward to working with all of you as we move forward on this journey to honor his memory.

Thank you.